

Hamilton College Summer Camp Health Record

Participation is prohibited without this completed form. Health Form must be received no later than 10 days prior to camp start date.

Camp(s) Attending: _____ Session or Camp Dates: _____
 (One form allows camper to participate in multiple camps, but list all camps above.)

Camper's Name: _____ DOB: ____/____/____ Age: _____ Gender: boy girl

Primary contact: _____ Relationship: _____

Day Phone: (____) _____ Home: (____) _____ Cell Phone: (____) _____

Emergency Contact (Other): _____ Phone: (____) _____

Insurance Co.: _____ Name of Policy Holder: _____

Policy/ID No.: _____ Insurance Co. Phone: (____) _____

Insurance Co. Address: _____

Please include a photocopy of your health Insurance card for our records.

Medical information below. Physicians signature required.

MEDICATIONS AT CAMP: Is it necessary to administer medication at camp? YES NO

Medications and dosages: Please list any Prescription or over the counter medications the child routinely takes or will require at camp:

DRUG	DOSAGE	SCHEDULE & INDICATIONS	COMMENTS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

All medication MUST be in its original container with an accurate pharmacy label and MUST be accompanied by physicians orders.

All medications MUST be given to the Medical Director or representative at check-in. This policy applies to OVER-THE-COUNTER and PRESCRIPTION medications!

Allergies to Medications: _____

Medical conditions, even if controlled (diabetes, seizures, etc.) _____

Date of most recent immunizations: Tetanus _____, Measles _____, Mumps _____,
 Rubella _____, Diphtheria _____, Poliomyelitis _____,
 Hemophilus Influenza Type B _____, Hepatitis B _____, Varicella (Chicken Pox) _____.

I have examined _____ and hereby certify he/she is able to participate in athletic activities.

 *Physicians Signature

 Date

 Phone

**You may attach a recent copy (within the past year) of a school physical (with physicians signature) if your child has no new medical conditions that limit his or her participation in sport activities. Complete immunization records should also be attached.*

Medical Treatment Authorization

In the event of an injury or illness, I give permission for my child, _____ to be treated by a qualified athletics trainer, nurse or licensed EMT and/or emergency room staff at the local hospital. I also give permission for medical staff to administer any medications as indicated above. In addition, I consent to have Hamilton College or above service providers use and disclose my child's protected health information for payment, treatment and health care operations purposes. Protected health information includes medical, billing and demographic information collected and/or created by above service providers. I understand that I will be responsible for all charges for health services by off-campus providers.

Signature of Parent or Guardian: _____ Date: _____

**IT IS ADVISED, PRIOR TO MAILING THESE FORMS THAT YOU MAKE A COPY TO HAND CARRY TO REGISTRATION.
 NO CAMPER WILL BE ALLOWED TO STAY WITHOUT COMPLETED HEALTH FORMS.**